THE HOSPITAL BULLETIN

OF THE UNIVERSITY OF MARYLAND

Vol. XI BALTIMORE, MD., MARCH 15, 1915 No. 1

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SCHOOL OF MEDICINE

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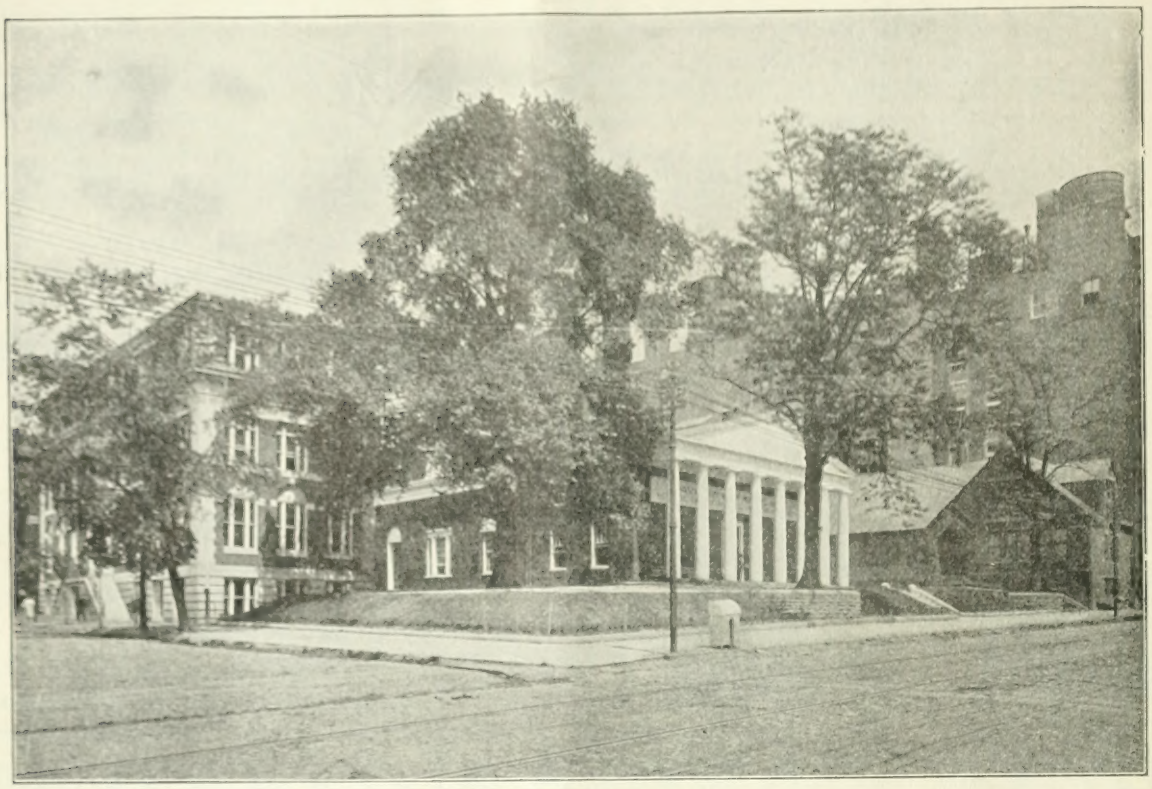

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THE SLUDER METHOD OF TONSILLECTOMY.

By RICHARD H. JOHNSTON, M.D.,
Baltimore, Md.

About two years ago Dr. Greenfield Sluder of St. Louis published his experiences with a new method of removing tonsils by means of a guillotine. His article was received doubtfully, because it did not seem possible to remove tonsils in the capsule with the instrument described. His high standing in the profession, however, led to trials of his method, with the result that many laryngologists now prefer the "Sluder" tonsillectomy to all others, because, when expertly done, it is not only the quickest method of removing tonsils in the capsule, but, what is more important, it leaves a smooth fossa, with anterior and posterior pillars intact. Sluder claimed in his early papers that hemorrhage was much less than after other methods. In my experience the bleeding is about the same as with other methods, but, because of the reasons mentioned above, it is to be preferred. If one follows Sluder's description of the different steps, the difficulties of learning the method are greatly increased. If, on the contrary, one follows what seems the natural plan with such an instrument, the method is easily learned. The secret of success depends entirely upon the proper manipulation of the guillotine, and, once this knack is acquired, no trouble is experienced in removing tonsils in the capsule in at least 95 per cent. of cases. Even small, flat tonsils, which at first sight appear impossible of seizure by the instrument, are almost as easily removed as the more prominent ones. Strange as it may seem, tonsils which project into the throat, with a narrow anterior pillar, are the most difficult of removal, for a reason which will be emphasized later. The instrument is shaped like the old Mackenzie guillotine. The hole through which the tonsil passes is more rounded and the blade more rigid, which is necessary for a successful operation because great pressure is required at this point. Formerly two sizes were made. It was found, however, that between the ages of 10 and 20 years an instrument between these two sizes was required. Sluder laid stress upon a bony prominence on the lower jaw against which the tonsil ought to be pressed, so that it could more easily be forced through the opening in the instrument. I have not found this necessary, and in every case disregard it. The method of using the guillotine is as follows: After the patient is anesthetized, a mouth-gag—I prefer Ferguson's, because it is introduced between the bicuspid teeth and is well out of the way—is placed in position. If the left tonsil is to be removed first, the blade of the guillotine is inserted from the right side of the mouth with the left hand. No tongue depressor is used, since the tongue is pushed away with the instrument. When the tonsil comes into view, if the lower part projects downward, the blade is turned in that direction to force that part of the tonsil through first. This accomplished, the blade is turned vertically and carried over to the right side of the mouth as far as possible, at the same time exerting pressure on the lower jaw with the rounded end. By pressing upward slowly on the bone the tonsil is coaxed out of its bed until the edge of the anterior pillar is seen. The blade is now driven partially home, just grazing the anterior pillar to prevent the tonsil from slipping

and the blade from cutting the pillar in the further manipulation of the instrument. The embeded or adherent portion of the tonsil now appears as a bulging mass covered by the anterior pillar. The ball of the right thumb pushes this mass through the opening of the instrument. If the tonsil is soft this is easily accomplished; if it is hard the pressure must be prolonged some seconds before the sudden "giving" sensation announces that the entire gland has slipped through and it is time to drive the blade all the way home. Great pressure is needed to cut through the tonsil, which is supplied by a "dog" which is passed through a small hole in the blade, while its right-angled process is pushed down over the flat end of the handle. The finger of the right hand is now pushed down alongside the blade and any shreds of tissue broken up, when the tonsil is removed en masse. When the anterior pillar is narrow it is more difficult to push the tonsil through. Occasionally, after the blade has cut through the tonsil, it will be found that too much force will be required to peel the tonsil out with the finger; then it is best to remove the instrument and to cut through the remaining shreds with the snare. In such cases the tonsil appears completely dissected out with the capsule covering it like a hood. After the tonsil is removed, sponges are packed in the fossa and held for a few minutes. The anterior pillar is retracted and the bleeding vessels caught with Jackson's clamps and tied off if necessary. The fossa is found perfectly smooth—so smooth that the vessels are grasped with difficulty. The right tonsil is removed in the same way, the instrument being manipulated with the right hand and the left thumb used to push it through. Occasionally, if the tonsil is too large for the small instrument, a small piece of tonsil tissue is left in the supratonsillar fossa or near the tongue; these are removed with the snare or cut off with scissors. Sometimes in flat tonsils it is impossible to remove the entire gland; the top is shaved off and the base left. Without dissection this is pulled out of the fossa and removed with the snare. The advantages of the method are: 1. The celerity with which both tonsils can be removed. 2. No dissection of the pillars is required, since the instrument dissects and enucleates at the same time. 3. Since no knife is used, the pillars are not injured, as is sometimes the case with the snare. 4. The field of operation is bloodless until the tonsil is removed, which does not obtain with other methods. 5. Since the field is bloodless, every step of the operation is seen, which is not the case with other methods if bleeding is at all free. 6. There is less traumatism, because the tonsil is removed with one stroke of the instrument. 7. The operation gives a deep fossa and more normal pillars than any other method with which I am acquainted. 8. In those cases in which bleeding does not occur, the tonsils can be removed in from three to five minutes.

807 N. Charles street.

PERFORATED GASTRIC ULCER WITH DIFFERENTIAL DIAGNOSIS.

By George H. Dorsey.

It must be remembered that this paper is limited in its scope to a discussion of the diagnosis of perforated gastric ulcer, with a view to presenting some facts as to the differential diagnosis. Lack and limit of time prevent the latter from being freely discussed in detail.

In describing the symptoms attendant upon the perforation of a gastric ulcer we should draw a very necessary distinction between those which are due to the perforation itself, and not the complications aroused secondarily, which early diagnosis and treatment could prevent.

When perforation occurs, there is a sudden onset of the most intolerable and agonizing pain. The pain is hardly exceeded in severity by any that a human being can suffer. The patient is always prostrate with agony. His face wears a deeply anxious expression, the eyes are wide and watchful, beads of perspiration stand out upon the brow, and lines are quickly graven on the cheeks. The patient breathes shortly and quickly; he cannot take a deep inspiration. Collapse is certainly not present, however, when the patient is seen within an hour or two, if it is to be measured by the ordinary signs, for the pulse is not rapid—it is usually not more than 80—and its quality is not much impaired.

Examination of the abdomen is resented. It will be found that the abdominal wall is tight; it is held with a rigidity that never for one minute slackens. The abdomen is retracted and never at this stage distended. Distension comes later. A most careful examination of the abdomen will reveal an area of more profound tenderness, and if possible, of more obstinate resistance, than the

rest. This area will be found in the middle line, a little above the umbilicus, or in the left hypochondrium. The pain radiates to the left costal margin and sometimes to the left breast. Vomiting may occur at first, but usually does not. It is accordingly of no value as a diagnostic sign.

The symptoms described are those due to perforation, to the sudden onset of the rupture in the ulcer. They are ample to permit of an assured diagnosis of some perforation, and of a probable diagnosis of gastric perforation, being made.

The early history of the case is of the greatest possible significance. We know that in all cases, other than the acute toxic ones, it is the chronic ulcer which perforates, and no chronic ulcer exists without betraying its presence by symptoms which to those capable of recognizing them are of the clearest significance.

What, then, is this train of symptoms which so closely typifies ulcer of the stomach? Certainly, its chronic character is important. The patient rarely fails to relate clearly and precisely that it has been many years since he first began to experience gastric disturbance. These were mild perhaps in their beginning, of short duration, and but little inconvenience to his general health and usefulness. He will tell us that as the years have gone by, the trouble has been of the same type, has gradually increased in severity until finally he has little or no relief. The second characteristic feature, and one usually clear to the patient, is the periodicity of attacks. Early in the disturbance he may say the spells came spring and fall and were not severely annoying. That they came most often without any reasonable cause, suddenly, and continued days or weeks without interruption. Each day of the attack was a repetition of the preceding, each meal producing the same effect; first, comfort for one to five hours, then pain, gas, sour stomach and vomiting.

But, in making a differential diagnosis, may not any or all of these symptoms be present in gall-stone trouble or appendiceal attacks? Yes, all of them. Then the chronic tendency, periodicity, pain, vomiting and gas are not within themselves characteristic of a previously existing gastric ulcer. It is not the location of the pain that tells the story; it is not the kind of pain nor its severity that points the way, but it is, first, the time of pain or other symptoms; second, the regularity of pain and other symptoms, and, third, the means by which the pain or other symptoms are relieved, that give the differential to gastric ulcer. During the period of an attack in gastric ulcer the patient complains more or less severely of pain, gas, heartburn and sour stomach which comes before meals. Usually one to five hours after a hearty meal the symptoms return, and just as surely and regularly as these symptoms present themselves they are controlled by food, drink, alkalies or irrigation. This peculiar cycle is the characteristic of gastric ulcer.

As we have already said, the chief pitfall lies in the close mimicry of the symptoms of appendicitis. In both the attacks begin abruptly, the pain is sudden in onset, acute, referred often to the epigastrium, or to the whole abdomen, and later it is upon the right side of the abdomen. But the history is the chief factor upon which to place reliance. The perforation in an appendix case is not preceded by any "indigestion," at least not of the gastric type.

In appendicitis of the acute perforative variety, a history of some slight pain or constipation is usually to be heard. Moreover, the rigidity in appendicitis is not to be compared in intensity with that in gastric perforation, nor is the agony so excruciating in kind. The relative tenderness and rigidity are different. In cases of perforated gastric ulcer they are never lacking in the epigastric region; in cases of appendicitis, they are only exceptionally there, and then are of no great severity.

One of the most perplexing difficulties which may confront the surgeon lies in the proper discrimination of acute catastrophes arising in the gall bladder from those which have their origin in the stomach. An acute perforation of the gall bladder may present identical symptoms, both local and general, and nothing but a careful analysis of the previous history can insure an accurate diagnosis. Above all in importance is the orderly sequence of events. There is method in the natural history of gastric ulcer; there are the definite attacks, appearing at certain times, eased by diet, instantly relieved by alkalies or by lavage. Such a definite periodicity is never seen in gall-stone disease. Then, again, the character of the pain in the two differs essentially. A sudden onset with severe epigastric pain, radiating to the right, sometimes to the left, and through to the back, with sudden cessation, without apparent cause or any treatment, are quite peculiar to gall-stone disease when no complications are present. These

attacks come irregularly, night or day, and bear no relation to food, though often wrongly called acute indigestion.

Perhaps the most disconcerting of the diagnostic disasters which have occurred are those in which an acute thoracic disease has been mistaken for an acute catastrophe in the abdomen. It is extraordinary with what accuracy an acute intrathoracic disease may clothe itself with the symptoms and signs of an abdominal disorder. In cases of pleurisy, especially diaphragmatic pleurisy, the onset may be sudden, the pain may be felt exclusively in the abdomen, the abdominal muscles may be tense, and the surface of the body extremely tender. The points of chief significance upon which stress should be laid in order to prevent a mistake of this kind being committed are: First, the temperature. This is the most important of all. It is rare in any case of acute abdominal lesion to find the temperature raised to 102° or more. In the acute thoracic conditions the temperature may range between 103° and 105°. Second, the rapidity of respiration. Third, the disproportion between the rate of the pulse and the rate of respirations. The pulse is not much over 100 in the acute lesions within the chest, while the respirations may be between 35 and 45. A pulse rate of 120 and a respiratory rate of 25 would be more commonly recorded in an abdominal case. Fourth, the condition of the abdomen in respect of rigidity and tenderness. There is never the same unchanging resistance of the abdominal wall in any chest condition as there is when the lesion is in the abdomen, nor is the tenderness more than superficial.

In connection with this, through the kindness of Dr. Bay, I am going to report one of his private cases of perforated gastric ulcer.

The patient was a young white man, aged 23 years. He was brought to the hospital by his physician, giving the history of having been seized suddenly on October 28 with a boring pain in the upper part of his abdomen. On examination the abdomen was tense, rigid and very tender in the upper part. His pain was intense, and his physician stated that he had given repeated doses of ¼ gr. of morphine and finally ½ gr. doses, which were pushed to tolerance, yet the pain persisted. By the way, that is almost characteristic of a perforated gastric ulcer; the pain is so intense that morphia will not relieve it.

On admission his temperature was 99.2°, his pulse 95, and respirations 20 to the minute. His leucocyte count was 15,600. He gave a history of having suffered from attacks of indigestion, with pain, gas, sour stomach and belching. The patient said he had suffered for some years (he could not state exactly how long) and had continued to grow worse until the crisis came.

He was taken to the operating room with a diagnosis of perforated gastric ulcer, placed under an anesthetic and his abdomen opened through a right rectus incision from the costal margin level with the umbilicus. When the peritoneum was opened, a peritonitis was evident and a quantity of bile was mixed with the serous exudate. The stomach was inspected and a large perforated ulcer found at the pylorus. An effort was made to close the hole with a suture, but the tissue was so necrotic it would not hold. A piece of omentum large enough to cover the perforation was cut off and a plastic bit of surgery done in sealing the perforation with it.

After closing the perforation, the posterior wall of the stomach was exposed and a gastro-jejunostomy performed. Free drainage was provided, the wound closed, and the patient removed to his bed in very poor condition. He remained unconscious and delirious in spells for four days, when he began to improve. On November 14, just fifteen days after the operation, his appetite was good and he was sitting up in a wheel chair. On November 24 he was discharged, it being just twenty-six days since he entered the hospital, his drain tract had closed, his appetite good, bowels regular, temperature and pulse normal, and pronounced cured.

ADDRESS DELIVERED BY HIS EXCELLENCY, PHILLIPS LEE GOLDSBOROUGH, AT THE FIFTH ANNUAL HEALTH CONFERENCE, FEBRUARY 8, 1915.

The progress of the State in any of its departments is first accomplished, not by the effort of a large body of its citizens, but rather by an individual here and there. And so it is that, in the adoption of laws, followed by their intelligent application and enforcement, which have made for the improvement of the health of the people of Maryland, I might name a distinguished man, and a few of his associates, who are richly entitled to the credit of having established a State Depart-

ment of Health, which, for the splendid work it has done and is now doing, challenges the admiration of all people.

Need I speak of some of its recent accomplishments?

First—The division of the State into health districts, presided over by trained sanitarians, or to be presided over by such men so soon as they may be had. There is, I am told, a scarcity of men with this equipment just now, but it is gratifying to learn from Dr. Welch that one of the great foundations in this country is seriously contemplating, if it has not already decided to do so, taking up the training of men for this work. These men being fully equipped for their work, appointed solely on merit by the State Board of Health, free from loss of position by any change in the political fortunes of the State, will work a boon for suffering humanity that is immeasurable.

Second—An act for the better preservation of the public health by preserving the purity of the waters of the State; providing for the supervision and control by the State Board of Health over water and ice supplies, sewerage, trades waste and refuse disposal, and for the maintenance, alteration, extension, construction and operation of systems and works relating thereto; providing for the raising of funds by counties, municipalities and sanitary districts; for the maintenance, alteration, extension and construction of the same, and prescribing penalties for violation of the orders and regulations of the State Board of Health made in connection therewith, and to appropriate a sum of money for carrying into effect the provisions thereof.

Third—Making more efficient the work of the Examining State Board of Physicians.

Fourth—The regulation of factory and workshop conditions, and requiring the owner of every factory, manufacturing and mechanical workshop, and of every store or other mercantile establishment employing five or more persons to register same with the Bureau of Statistics and Information, and providing for the granting of licenses and supervision of conditions under which the work is done by the Chief of the Bureau of Statistics and Information, and particularly to ascertain, after consulting the records of the local Health Department or Board, or other proper local authority charged with the duty of sanitary inspection, the presence of any infectious, contagious or communicable disease, or the existence of any unsanitary conditions in or about factory, room or apartment.

Fifth—An act making more stringent the provision that the physicians shall, in writing, over his own signiture, give notice to the Board of Health or Health Officer of the city, town, county or district, of the presence of infectious or contagious diseases.

Sixth—An act requiring the local boards of health of the counties of the State to meet semi-annually in the months of May and October, and as much oftener as they may deem necessary, and that they shall act in conjunction with the State Board of Health, and shall report to said board such facts in reference to the sanitary conditions of their respective counties as they may deem important and necessary.

Seventh—An act to provide for the medical examination of school children and the promotion of their health, and authorizing the Board of County School Commissioners of any county in the State to appoint one or more school physicians and assign one to any public school within the limits of such county, and to provide such school physician, when so appointed, with proper facilities for the performance of his duty, the physician being required to make a prompt examination of all children referred to him, and to file a written report of such examination; that the principal or teacher of any school to which a school physician has been assigned, shall refer to the physician every child returning to school without a permit from the health officer of the Board of Health after an absence on account of illness, and every child attending such school who appears to be in ill-health or is suspected to be sick with any infectious or contagious disease shall be immediately excluded from the school, under the provisions of the general statutes for sanitary regulations in force in such town or district.

Eighth—An act amending the statutes relating to State Registrar of Vital Statistics, and providing that each election district, city and incorporated town shall constitute a registration district, permitting the State Registrar, with the advice of the local Board of Health, to designate a competent person in each registration district who shall act as local registrar, and shall within his district receive death certificates, issue burial permits and receive birth certificates, and perform such other services as the local Board of Health may direct; and further, that it shall be the duty of every local

registrar on or before the 5th day of every month, to transmit to the State Registrar of Vital Statistics, in envelopes furnished for that purpose, the originals of all certificates of birth or death remaining in his possession on the last day of the month next preceding, and at the time of mailing his returns to the State Registrar he shall also mail to the County Registrar a copy of all certificates of births or deaths certifying that it is correct, under his own hand.

Men who have accomplished so much can do more. And so it is tonight that I make an appeal for your help in waging a campaign that shall bring about ways and means to care for the negroes of the State who are victims of tuberculosis.

WHAT WE ARE DOING.

The State has its own tuberculosis sanatorium at Sabillasville, at which an average of 391 patients were cared for during the last year, and which costs the State $140,000 per year. The State also has a small tuberculosis sanatorium at Salisbury, known as the Pine Bluff Sanatorium, which is running at a cost of $10,000 per year, and which cares for approximately 25 patients. In addition, the State is contributing largely to the support of the Eudowood Sanatorium, which cares for some hundred patients and receives an appropriation of $25,000 per year.

The Jewish Hospital for Consumptives of Maryland at Reisterstown provides for some 55 patients, and receives an appropriation of $6500, and the Allegheny County Tuberculosis Sanatorium, which makes provision for approximately 25 to 35 patients, receives an annual appropriation of $1000.

SITUATION AS AMONGST NEGROES.

All of the above institutions, however, take only white patients. A glance at the records of the State Board of Health shows that, while the population of the State is approximately five-sixths white, the number of deaths among the negroes dying of consumption is approximately one-third of the total number of deaths from that disease. The disease would, therefore, seem to be much more prevalent amongst the negroes than the whites.

WHY THE NEGRO URGENTLY NEEDS HELP.

Not only do humanitarian motives demand that we do something to stop this frightful death rate amongst the negroes, but in addition, we must see from even a selfish standpoint that we can never hope to make great inroads on this disease amongst the white race so long as we allow the negro to be a center of infection.

This is especially true when we consider the fact that the negroes cook our food, put it on our table, wash our clothes and care for our children.

It would, therefore, seem that the weakest spot in our fight against tuberculosis is the negro, and it is to be hoped that something definite can be worked out for him in the near future. As a layman I cannot say that it is best to establish a central sanatorium. On the other hand, there are close students of this question who say that the more advanced method is that of local sanatoria.

A writer has said:

"The utility of hospitals is not to cure the sick. It is to teach mercy. The veneration for hospitals is not because they cure the sick; it is because they stand for mercy and responsibility. The appeal of physicial suffering makes the strongest attack on our common humanity."

We must help the afflicted, or we, and our descendants, will become afflicted.

At the bottom of every fight for principle you will find the sentiment of mercy, and I plead for mercy for those unfortunates—not alone for themselves—great as is the debt due them—but also because, if it be not fully given, those of our own race must ultimately suffer.

So much have we heard in these days of the new freedom about the conservation of forests, streams and mines, the care and protection of our natural resources, to all of which I give most earnest approval. But far and above this is the conservation of the health of the people of a State and nation. I beg you to enlist under the banner of the Maryland Society for the Prevention and Relief of Tuberculosis, which association, under the leadership of Dr. Henry Barton Jacobs, is soon to wage State-wide warfare against the white plague, with the hope that in no small measure it shall be driven from the homes of countless sufferers.

These poor unfortunates need that you shall champion their cause, and no man knows better than I the high order of service that the members of the Medical and Chirurgical Society are capable of giving. I pray you that this plea fall not on deaf ears.

OUTLINE OF SPEECH OF DR. THOMAS FELL, DELIVERED AT THE BANQUET OF THE GENERAL ALUMNI ASSOCIATION OF THE UNIVERSITY OF MARYLAND, FEBRUARY 20, 1915.

In the course of my travels during last summer I was in London, where I gave particular attention to the system of organization which controlled the University of London, and subsequently I went on to Oxford for a short visit.

I gained much valuable information in regard to the plan of affiliation of colleges adopted at these two centers, but in the abstract I learned that books are nothing, neither have they a title to interest nor a place apart from men; that a school exists not to preserve documents and hand down the dry husk of letters, but rather to inspire and stir great souls to lead the living present and to point to a grander future; that a seat of learning is, and must be, not less than an intellectual center—a social force.

There is today a special and pressing need to cry out for a movement which shall throw open the gates of life.

Education is the key of Southern as of Northern security; education does not mean political service or racial antagonism; illiteracy is inconsistent with democracy.

A generation ago educated people were a privileged, separated, patrician, Brahmin caste. They spoke the same dialect. They quoted from the same classics. Then one day the modern world was touched and transformed by the spirit of democracy.

A new test was applied for the worth of life, the test of service. A man must be not only good, but good for something.

We speak of a rich man as worth a certain sum, but the spirit of democracy first asks how much is he worth? Is he worth having? Does a rich man perform a public service? Are his riches, as Mr. Ruskin once said, his "wealth" because it is "well" with him, or should they be called his "illth" because it is "ill" with him. Or as Mr. Ruskin remarked in another place, suppose a man in a wrecked vessel tied a bag of gold pieces around his waist, with which later he was found at the bottom, should we say as he was sinking that he had his gold or that his gold had him?

Precisely the same test is to be applied to education. How much is it worth? Is it creating a fit instrument for the service of the modern world?

It is not a question of higher or lower education. It is a question of a person, rich or poor, who is to be shaped, hardened, tempered for the service of the world, and the best education for each person is that which draws out the most of that person and applies him most effectively to the world's service.

Democracy, says Mr. Lowell, means not "I am as good as you are," but, "you are as good as I am."

The average alumnus of the Maryland University, I am able to say, takes equal rank in the practical affairs of life with the graduates of more pretentious institutions, and I think there is noticeable among them a well-disciplined thoroughness of workmanship in whatever they undertake to do, and a spirit of liberality of thought and feeling which reflects the highest honor on their Alma Mater.

However much the University may have failed to have as yet reached the standard raised by its more ambitious friends, it has at least succeeded in this one thing, of educating a large number of men in such a way that, when taken in the main, they may be said to have exerted and to be still exerting a wholesome and refining influence in their respective communities.

We look, therefore, to the alumni to add to the fair fame of this University to which you belong. She looks to you, the living Maryland, to build upon the foundation so nobly laid in the past.

A CONVERSATION ON THERAPY.

By John C. Hemmeter, M.D., Phil. D., LL.D.

After the International Medical Congress in London in the August of 1913, the Association of German Physicians and Naturalists convened in Vienna and the International Congress of Physiologists at Groningen, Holland. At the many informal gatherings of the physicians and naturalists, I was impressed with an all-pervading truth that was accepted by everyone present as a finality, and this was that medicine was becoming too broad and extensive as a science and art to be controlled entirely by one individual and that thereby the genuine inward essence of therapy suffered. Some of the speakers were prominent professors in German, Austrian and Holland uni-

versities a few of these professors were relatives and it made a very deep impression to be told that the peculiar impressiveness of some of the great clinical masters rested in their ability to understand the personality of the patient.

When I first came to Berlin, about 1880, the three great clinicians were Gerhardt, Senator and von Leyden. They are gone and busts of the three have been erected. During my visit of last summer, I found no fourth place Goldscheider, Hiss and Krauss. The only one of these three who will stand comparison with the old trilogy of Gerhardt, Senator and von Leyden is Krauss and it was my good fortune to have many delightful interviews with this master clinician. Krauss, like Strumpel, must be regarded as one of the greatest contemporaneous teachers of medicine in Germany. Both are teachers of the most peculiar magnetism and the rarest charm, possessing the gift of suggestion to an admirable degree, and the secret of their success as clinicians is their capacity for finding their way into the psychic "ego" of the patient.

In this connection I desire to bring to your notice an article by Prof. L. Krehl, of Heidelberg (Uber Therapie) in which he says that "the continued extolling and praising of the extraordinary progress of the art of treatment is not only unnecessary but I consider it harmful like everything that is inwardly untrue. Fifty years ago the art of healing was valued as a natural science and the physician as a representative of progressive natural science tendencies."

The emphasis on the word healing might provoke contradiction, for there can hardly be two greater antagonists than science with its problems and aids for all eternity and the temporary demand to help a human being. I think it was Wunderlich who stated that the relations of our problems and duties as physicians was not to *treat disease*, but to treat *diseased human beings*. In reality, we are always treating a *diseased personality*. The treatment, if it aims to be given with completeness, can hardly ignore the importance of psychotherapy, for the objective structural and physical changes which a disease evokes are of necessity reflected in consciousness and it is beyond all doubt that after the physical conditions have gone back, the full train of psychical associations and memories may and do continue, even in individuals who are not psychically abnormal.

That which we call "*disease*" is an abstraction from observations and conceptions on natural processes, running their course in a living thing. It is assumed much more frequently than we have a right to assume that the various individuals are alike in their organization and that, therefore, they should react alike to the system of external and internal influences which we designate as the cause of the disease, irrespective of the fact that the combination of moments acting in the etiology are in the various cases never completely alike.

The demands of didactic discipline and of the clinic, and also the demands of our understanding and human indolence, force us to formulate certain schemes, but I am of the opinion that in our schemes we very often forget that which is essential in the process, and we should not be astonished that the disease processes are not alike in different human beings. It is rather amazing that under the similar etiology we meet with relatively similar phenomena so often.

There are, in reality, a relatively small number of proper and peculiar causes of disease, and yet so many complicated diagnostic questions, such unexpected and ever new combinations of signs and symptoms. This riddle partially solves itself by the large number of possibilities of neurogenic and clemotropic deviations, the narrowed or the extremely expanded circle of reflexes which we call the individual variation of the psychic and physical personality.

Right here we meet with the most disheartening difficulties and problems of actual therapeutics. Even the most ordinary chemically pure medical substance acting upon the cells of one single organ does not influence them in different healthy individuals in the same manner (adrenalin). As a rule, we are familiar only with entirely coarse effects on the human being. Every foundation is lacking for the understanding of individual variations. We have become satisfied to express these mysteries of personality by the coinage of new words. Words give a fictitious satisfaction in place of understanding. All of the discussions of hypo- and hyper-tonicity of the vagus and sympathetic nervous system, though in some respects not felicitous, yet stimulate observation and give a new prospect for the study of personality.

In addition to our lack of understanding of the variations of individual reactions, we are perplexed by an immense complexity and possi-

bility of variation of even the simplest diseased condition. In view of all this, how can any one preserve his self-knowledge when he deceives himself that he personally cures disease successfully and rationally? I am of the opinion that the habitual overestimation of our therapeutic ability brings the immense danger that the physician is led away from the best which he has, viz., from his adherence to the investigation of nature, for this requires conservative critical judgment, unconditional surrender to truth, and bowing under the hard even yoke of the facts. It appears to me hardly possible that a man who daily intoxicates himself on fictitious successes can remain critical and inwardly veracious. It is so easy to transform an effect which we are exerting as a man upon a diseased man into a scientific success.

Let us have a few practical examples. I will not take them from my own specialty, where the organ, stomach and rectum intestine, can be directly seen with the X-rays enterotroscopy-proctoscopy, etc. Take valvular disease of the heart or arteriosclerosis, for example. Undoubtedly we may help a great deal by careful preservation of the patient's strength, adjustment of his conditions of living, eventual increase of the systolic power of the heart by the so-called heart tonics, the selection of a rational diet, etc. But if this whole status and treatment shall turn out very well, there must be an abundant experience, sagacity, circumspection and love of mankind to co-operate, and even then we cannot conceal it from ourselves that we have hardly taken the first step to influence the myo and endocarditis, the sclerosis of the vessels, etc.

It is a similar condition of affairs that appertains to diabetes. Nobody who understands this condition only partially would undervalue the extraordinary significance of dietetic management, which helps the patient directly because it improves the power of achievement of his metabolism, but all of this is a disappearingly small part of the real cure of a condition that is almost completely hidden from our understanding in its real entity and causes.

When we accomplish very much, we are useful servants of nature, but in the present exaggerative tendencies, do we not often mistake ourselves for masters of nature, and as we can never be that, we should not fail to be impressed with the fact of how much better a good servant is than a bad master. One should fear physicians who have lost their loyalty and respectful fear of nature.

It has frequently been emphasized that the duty of the physician to heal was always the same and forever will remain unchangeable, irrespective of the standing and achievements of science. At all periods of history of the human race, every one who felt himself inwardly as a physician has aimed to help his patients with all the powers at his command. This is so axiomatic that one should not speak of it, but if we follow a part of our modern literature, we would gain the impression that the real treatment of disease did not set in until the end of the nineteenth century and since then has developed in an unprecedented manner. This unusual claim for modern therapy might be disregarded, for we, as members of this epoch and contemporaaeous with it, could ignore therapeutic extolling, but false ideas are contagious and they create the danger to ruin the convictions of entire generations, and with these convictions human beings are ruined also.

I have already stated that the quality of the observer of nature is slowly undermined by an exaggerated opinion of personal effectiveness in therapy. This is bad, but it is not the worst. The therapeutic clamor brings it about that our treatment itself, or that which is best in it, the sympathetic insight into the *ego* of the patient, suffers from it.

The physician must and shall help his patient as much as is in his power. This help can only be unified and complete just as the sufferer is a unity and every human sufferer represents something peculiar. Presumably this may be considered axiomatic, but then it may be so self-evident that we forget it daily and do not act accordingly. Instead of giving the sufferer a completeness in treatment directed to both the physical and psychical individual, we usually go about the matter in the following way: A man comes to us with some kind of complaint and we examine the diseased organs and the cause of their disturbance of function. We endeavor to influence these causes favorably according to contemporaneous rules and views. In the most favorable case we have a care to interest ourselves in the peculiar course and progress of the disease which is conditioned by the individual bodily peculiarity; that constitutes the much discussed *"individualism"* in treatment. A *very* painstaking clinician may then even take cognizance of the personal form of the

reaction to the measures that have been introduced in the treatment. All of this constitutes a very high ideal of clinical conception and a lofty standard of medical ability. But it does not constitute the rule and will become less and less the rule the more the physician aims to replace thoroughness by a tendency to acquisition in mass production, i. e., he aims to make up his receipts by a clientele the very size of which indicates that it is impossible for him to be thorough. How can he occupy himself with the personality of a patient when he hardly has time to go through the objective means of diagnosis? The patient loses the most valuable of what a physician has to give, viz., the intimate solicitude for the psychic man.

There has been much discussion recently that medical and religious activity have sprung from the same root and that now they are again uniting in a common road. One sees a great deal in lay journal literature of the physician having to replace the priest or parson. I have seen nothing of the sort, in reality affairs are quite different, for very frequently the physician does not know his patient as a personality and with the present tendency to order our activity, into the events of life as a *trade,* this defect will increase. A man buys a pair of shoes, just so he goes to a physician, who does not supply shoes, it is true, but he may supply a gall bladder with an operation or Carlsbad water. Now that may be a very effective and completely sufficient help, and according to this scheme our entire modern therapeutic measures are arranged.

Certainly we must progress energetically in our efforts to understand and influence single disease processes. The largest part of our daily biologic work is devoted to this problem, and it is entertaining to muse upon the hypothetical ideal medicine of future milleniums, which we shall have to conceive as extremely developed. I was almost going to say we would have to *conceive* it as *inconceivably* developed. This tautology is forced upon me by the realization that it is impossible to conceive of what medicine will be even a hundred years hence, much less of a thousand years hence. Try to picture to yourself whether it was in the range of human possibility for Galen (131-201 A. D.) to conceive of the medicine of our age. Would his reason have balked at the thought of anaesthesia, of vaccination, of anti-toxic sera for many diseases, of almost bloodless operations on all organs of the abdomen, pelvis, thorax and even of the brain? It was not until 1628 that Harvey published his studies on the circulation of the blood. Our mind is itself a product of the experience of the time in which we live and of a short time that has preceded it. It is not an instrument capable of projecting our consciousness into the future—at least, only two domains of knowledge make such an attempt, religion and philosophy.

When we consider our progress great, we shall have to remember that it is only relatively great, i. e., when compared with the knowledge of the past. And the knowledge of our time will appear diminutive to the critic of the future. It is a fact that in spite of operative progress and the blessings of immune and antitoxic serum, there have been great physicians at all times, but they made use of an element which is today almost totally disregarded, and that is this: For the complete life of the individual, everything depends upon preserving the patient as a personality, and in this the physician must see the sum of his duties.

We often give stones instead of bread because we disregard the personality and limit ourselves to diagnosis and drug or operation. Every man stands alone and individually for himself in this world, and yet he is completely fitted into it by his personality. This makes a demand even when the physical disturbance of individual organs have been largely met.

The full and complete biologic development of our time is that which leads to diagnosis and logical therapy. This is the fundamental and indispensable requisite. It is that which constitutes the themes of our teaching, it is impossible to do sufficient of teaching in this respect. For the human being is not living that can at the present day control the superabundance of the biologic work that is done on the human body. But a certain idea of competence of these methods is a premise of therapeutic ability. We have to do more than this; it is true that the physician's activity is not entirely natural science, nor entirely art. There is a something in it which, to me, cannot be comprised in the terms art and science. Perhaps I could call it humaneness, by which I desire to express a simple, sincere and intimate knowledge with the inner man. Humaneness I mean in the sense that Cardinal Bembo and J. H. Symonidas applied it to Raphael in saying that what *distinguishes the whole work of Raphael is its humanity in the double sense* of the *human* and the *humane.* Science and art has led us to

the exclusive treatment of the organs most prominently sick, but the humaneness, if present, will direct the physician to the disturbed psychic equilibrium. A sick human being is sick as a totality, not in its parts only. The totality has to recover, and to this belongs his psychic personality.

"That only a good man could be a good physician" I doubt very much, for there are hardly any good men, but he must be a lover of nature, of more than ordinary knowledge and ability, a humane man, humane to the sufferer and filled with a consciousness of a high destination. Between the two, the physician and the sufferer must be the inner bridge without which the understanding of man to man cannot cross. I deem it impossible to be a true physician to people of a completely alien conception of life. One might treat them for a valvular defect with digitalis and so on, or one might operate them for an appendicitis, but a complete physician one cannot be to them because this psychic bridge is missing.

So the physician stands as a human being among the people. That again is axiomatic. But reflect upon it. How rare it is in questions of humane conception. He nowadays occupies a very peculiar position. The love of the sensational, the passion for notoriety, the éclat attending public recognition for fictitious achievements, which not *he* has done, but which nature has done for him—all this is bringing it about that he does not understand many human beings and many human beings do not understand him. Then picture to yourself, as a proof of this, the frequent demand made upon the physician by the people to be told nothing but the truth and the whole truth and at the same time intimating that they do not want to be told that there is anything seriously wrong and that everything will be in good order presently. I really do not know where it is going to lead to, when a large part of the physician's problems during long and abnormal conditions consists in the most ordinary and ponderous lying (Krehl). Of real comfort there is rarely a word said, and this I interpret as being one of the consequences of the evil that all of our present diagnosis and therapy is adjusted exclusively to the management of one organ and we give out when this therapy gives out, which is very often the case.

So, in brief, there must be more genuine humaneness in the practice of medicine. The patient and the physician need a conception of life on the basis of humaneness in which they mutually find and understand each other.

I have not hesitated to bring these subjective views of Krehl and others that have certainly not originated in the laboratory before you. In conclusion this profound clinical thinker states: "I have suppressed a certain amount of embarrassment at the thought that my ideas might be misunderstood and declared fantastic, but I brought them before you, nevertheless, because I am convinced that the physician's work cannot be comprised completely under the terms *art* and *science*, but that a third *'something'* must enter to make the therapeutic trilogy complete and that this something, whilst it cannot be taught in the schools, yet it should permeate all physicianly action as the ocean is permeated with the taste of salt.

BOOK REVIEW

International Clinics. Edited by Henry W. Cattell, M.D. Volume II, Series 24. 1914. Philadelphia and London: J. B. Lippincott Company.

This particular number opens with an article on Health Before Birth, by J. W. Ballantyne, M.D., and closes with one on The Teaching of Sex Hygiene, by Maria M. Vinton, M.D., New York city. Interspersed between these are a number of good practical articles on the various specialties, to wit: Present Status of the Roentgen Rays, Intestinal Short-Circuit, with Report of Cases; The Surgical Treatment of Gallstones, Conservative Versus Radical Treatment of Tuberculous Joint Disease, etc., etc. Of especial interest to our readers is A Word in Behalf of the Open Operation for the Proper Fixation and Repair of Fractures, with Report of Cases, by Frank Martin, M.D., professor of operative surgery and clinical surgery in this institution.

Dr. Henry Krehl, class of 1912, of 1217 Hanover street, Baltimore, was rendered unconscious in an automobile accident recently. His car was jolted from its course by running over a dog and crashed into a tree, throwing the doctor to the roadway. He is suffering severely from the shock and bruises.

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Editor . . . . . NATHAN WINSLOW, M.D.

BALTIMORE, MARCH, 1915

THE RECENT MEDICAL EDUCATIONAL CONFERENCES HELD IN CHICAGO.

In February of each year several bodies interested in medical education meet in Chicago. Those that concern us specially are the Council on Medical Education of the American Medical Association, of which Dr. Arthur Dean Bevan is chairman and Dr. N. P. Colwell, secretary, and the Association of American Medical Colleges. The Council on Medical Education has no actual jurisdiction over the medical institutions of this country, but it exerts a powerful moral influence on them through its inspections and classifications that are published at frequent intervals in the *Journal of the American Medical Association*.

This Council has done an admirable work during the past 10 years. In 1904 there were 166 medical colleges in the United States; at the present time there are less than 100, and the number is decreasing annually. It is probable that 75 or 80 schools will survive the pressure eventually.

The number of medical students and graduates has also fallen off enormously.

For some time past medical schools have been classed as A and A—, B and C.

An A school was acceptable, but an A+ one was still more acceptable. B schools were lacking in many particulars, and needed extensive reorganization, while C schools were regarded as hopeless.

At the last meeting of the Council the rating of A+ was abolished, and schools were rated as A, requiring two or more years of premedical collegiate work, and A, requiring one year of collegiate work in chemistry, biology, physics and French or German. Eighty-four schools now require, at least, the minimum of premedical work mentioned, consequently B and C schools are becoming very scarce. In practice, it has been found very difficult to administer the one year of prescribed college work in an efficient manner, and it is almost certain that two years of premedical collegiate work will be required in 1918. As the result of the present entrance requirements, there has been a most remarkable reduction in the number of freshmen entering those schools that have enforced these requirements for the first time; thus, the University of Louisville had 108 freshmen in 1913-14 and 5 in 1914-15. The Medical College of Virginia had 117 in 1913-14 and has less than 30 this session. We had 98 last year, and 32 are enrolled this year. While the requirements certainly will not be lessened, it is possible they may be made more elastic, especially in the matter of foreign languages. Spanish, Italian or some other foreign language may be allowed instead of French or German.

The Association of American Medical Colleges is composed of over 50 members, comprising most of the best schools of the country. No college not in class A is eligible for membership, and if a member drops to class B it is suspended until it has been reinspected and rerated. If it cannot meet the requirements after a reasonable time for reorganization, it is dropped from membership. This association holds its membership rigidly to its requirements, and two very prominent institutions were called to account at this meeting.

THE FACULTY OF PHYSIC FUND.

According to Mr. Charles Markell, treasurer of the endowment funds of the University of Maryland, the Faculty of Physic Fund, which has been set aside for the endowment of the department of pathology, amounted to $21,852.92 on January 11, 1915. Since that time $26 has been received, making the fund $21,878.92 at this time. We need $100,000. The times are hard, but we are still striving to raise this fund, which is a necessity.

ITEMS

Dr. Arthur P. Herring, secretary of the State Lunacy Commission, has returned from South Carolina, where he went at the request of the State authorities to investigate the conditions at the Columbia State Hospital. As the result of his special investigation a number of improvements in the institution have been recommended by Governor Manning.

Dr. Francis M. Chisolm, class of 1889, formerly of The Rochambeau, Washington, D. C., has moved to Annapolis, Md. His present address is Route No. 2, Annapolis, Md.

Dr. Robert P. Bay, class of 1905, announces the removal of his offices to The Walbert, 1800 N. Charles street, Baltimore, Md. His practice is limited to general surgery. Consulation by appointment.

Dr. Charles W. Roberts, class of 1906, is superintendent of the Douglas Surgical Institute and Infirmary, Douglas, Ga. In a recent letter from him he writes: "I hope to get up to see my friends in Baltimore soon."

Dr. A. M. G. Dukes, class of 1914, is connected with the Cambridge Hospital, Cambridge, Md.

Dr. Joseph C. Enos, class of 1904, of Charleroi, Pa., was in Baltimore last week. While in the city he stopped at the Belvedere.

Dr. Frederick L. Detrick, class of 1913, is located at the Metropolitan Hospital, Blackwell's Island, New York.

Dr. William Culbert Lyon, class of 1907, Assistant Surgeon, Medical Reserve Corps, U. S. N., formerly of 1518 Mt. Royal avenue, this city, is still on duty at Galveston, Tex. He is assistant surgeon of the recruiting district of the United States Navy in Southeastern Texas, established about two years ago. This district was made necessary on account of the size of Texas and by reason of the great number of desirable recruits that are obtained in the State. Galveston was selected as the headquarters by reason of its being the chief seaport city. Dr. Lyon is in charge of the medical department of the Galveston office. Prior to his detail at Galveston he was on duty at the Richmond (Va.) station.

Dr. J. C. Perry, Surgeon, U. S. P. H. S., class of 1885, writes us as follows:

"Chicago, January 10, 1915

"The Hospital Bulletin Co.,

"Baltimore Md.:

"Dear Sirs—I am inclosing money order for $1 in payment of bill for THE BULLETIN.

I left Panama in April last and went to Europe. Am now temporarily in Chicago, studying the City Department of Health.

Until further advice, send THE BULLETIN to 610 City Hall Building, Chicago, Ill.

"Truly yours,

"J. C. Perry."

Miss Lucy B. Squires, who has been located at 32 South Washington avenue, Columbus, Ohio, has moved to 21 Perry street West, Savannah, Ga.

Dr. J. Holmes Smith, Jr., U. S. P. H. S., has been temporarily transferred from New York to New Orleans, La. His present address is 163 Dryades street, New Orleans, care of U. S. Public Health Service.

Dr. James A. Nydegger left recently to visit Mr. and Mrs. George L. Carnegie at their winter home, Plum Orchard, Cumberland Island, Fla. He will later join Dr. L. M. Tiffany at the Canarural Club, near Titusville, whose guest he will be for several weeks' shooting.

Dr. Henry Chandlee, class of 1882, announces the removal of his offices to 2000 North Charles street, where the newest equipment has been installed for Radiography and X-Ray Therapy. Dr. Chandlee is associated with Dr. R. Tunstall Taylor, professor of orthopedic surgery at the University, in orthopedic work as well as doing general radiography. Office hours 12.30 to 1.30 daily, except Sunday. Other hours by appointment. Telephone, Homewood 2459. Dr. Chandlee resides at 742 West North avenue.

Dr. John S. Fulton, State Health Officer, has returned from a trip to Jacksonville, where he attended the annual meeting of the American Public Health Association. Dr. Nathan R. Gorter, head

of the City Health Department, also attended the meeting.

Dr. Fulton made the trip both ways by sea, arriving on the steamer Somerset. He was fortunate in escaping a bad storm which swept over the North Atlantic coast at that time, but did not extend below Hatteras. Dr. Fulton said that the first intimation the people on the Somerset had that there had been a severe storm was the sight of the large number of vessels that had taken refuge at Norfolk and inside the Capes and were coming out as the Somerset was coming in.

On Wednesday, January 27, 1915, a most enjoyable and successful subscription dance for the benefit of the University Hospital was given at Moose Hall, 410-12 W. Fayette street, by the January committee of the Board of Lady Managers. The committee in charge of the dance was as follows: Mrs. Howard M. Towels, chairman; Mrs. Louis Fehsenfeld, Mrs. Garth Clopton, Mrs. B. F. Hearn, Mrs. A. M. Shipley, Mrs. Gordon Wilson, Mrs. J. C. Hemmeter, Mrs. T. J. Hance, Mrs. Winfield Yerbey, Mrs. William Wilkens, Miss M. Cottingham, Miss E. Winslow, Miss M. Adams, Miss J. Buckingham.

REPORT OF MRS. HOWARD M. TOWELS, CHAIRMAN.

Referring to the names of our committee for this, our month, we realize from our large committee you have a right to expect great things of us, and we hope our month's work will not be a disappointment to the ladies of the Auxiliary Board.

Although our committee consists of 14 members, very little visiting of the wards was done, with the one exception of our good and faithful member, Miss Cottingham. Miss Cottingham regularly visited the children, taking them candy, books and toys. A great many of us had engagements on our special meeting days; then, too, we had many stormy days during January, which accounts somewhat for our neglect this year.

Now, we will come to what we really did do. Our former custom has been to give a card or theater party to raise funds for our committee. This year it was decided to give a dance instead of the other diversions, as dancing has somewhat superseded and become more popular than the other forms of entertaining. Our committee put forth its best efforts to make it a success.

Through the splendid work of another good and faithful member we were able to secure the Moose Hall, located on Fayette street near Paca, for the occasion, at a greatly reduced rental; in fact, for practically the expense of lighting and heating. This was made possible by the interest taken in our committee work by Dr. W. G. Clopton, who is physician to the Order of Moose. Dr. Clopton went before the Benefit Board of the Order and outlined our plans and spoke of the worthy object of the cause. From the doctor's friendly interest we were accorded not only the hall at a greatly reduced price, but the courteous attention and help of the officers and members of the Order. These gentlemen never failed to help us whenever possible. Mr. Griffin, the manager, allowed the decorations which had been used on New-Year's Eve to remain, which added much to the beauty of the occasion.

Messrs. Halliday Bros. donated palms for the stage, and Dr. Clark, a resident of the University Hospital, loaned us banners and pennants, which gave the hall a decided U. of M. look.

We had tickets printed, which sold at the popular price of 50 cents, and our friends, including many of the staff physicians and all the residents, helped make the dance the success it proved to be.

Miss Cottingham, a committee of one, had in charge the sale of caramels made and donated by the members and friends of the committee. Same were sold by two little girls dressed in white, with University colors. The caramels were tastefully wrapped and sold for 5 cents per package, and the sum realized was $7.10. We also realized $8.20 clear of expense on the sale of orange ice, which we sold at 10 cents per plate.

In one of the conversations the chairman had with Mr. J. A. Cassidy, president of the Day Printing Co. (and who also is dictator of the Order of Moose), he outlined to your chairman *an advertisement idea* of a "souvenir program," in which his company would allow the committee 50 per cent. gross of all the advertisements he was able to secure. As no risk or expense was assumed by the committee, the chairman accepted his proposal. The idea was very successful, and the committee will realize about $275 from same. At this time the chairman is unable to state the exact amount, as the collections are now being made by the Day Printing Co., and it will be a few days before a complete statement can be made by them.

The early part of January, Mrs. Randolph Winslow spoke to me of a most deserving case of a colored woman who had an abdominal operation performed; the doctors ordered a support to be made; the woman, being poor, was unable to pay for same. Our committee decided to buy the support, which was done.

We have a fund in bank of $128 from last year (1914), arising from a card party held at the Stafford Hotel. This fund our committee decided to allow to remain in bank for future use.

In addition to the above, we herewith submit all collections and disbursements for the month:

COLLECTIONS.

Sale of tickets	$195 88
Sale of caramels	7 10
Sale of water ices	22 25
Mrs. Nathan Winslow, treasurer	10 00
Mrs. Louis H. Fehsenfeld (donation)	5 00
Proceeds from Day Printing Co. (assumed)	275 00
M. S. Levy & Sons (donation)	10 00
Dr. A. M. Shipley (donation)	8 00
	$533 23

EXPENDITURES.

Music	$15 00	
Mails, etc	2 00	
Stamps	2 00	
Brace for colored woman	3 50	
F. C. Stolpp, water ices	12 80	
Moose Hall	10 00	
Permits, Baltimore city	6 00	
Printing tickets	1 75	
Programs	9 00	
		62 05
Net balance for month of January, 1915		$471 18
Balance in Bank, 1914		128 00
Total amount our committee now has		$599 18

We regret we cannot at this time say what will be done with this money. The chairman had a talk with the chairman of the "house committee" of the University Hospital in reference to the use of the money our committee has. We are desirous of making a permanent improvement in one of the wards, but at this time nothing definite has been decided on.

The chairman would not consider this report complete unless she heartily thanked her committee for their splendid help and co-operation in this month's work, and the chairman thanks our newest member, Mrs. Benjamin F. Hearn, for her untiring efforts in disposing of half a hundred tickets for the dance.

Respectfully submitted,

(Signed) Mrs. Howard M. Towles.

Since closing the report the House Committee of the University Hospital received a letter from Dr. and Mrs. Joseph Smith, expressing their satisfaction relative to certain contemplated improvements to be made in the children's ward, known as the "Jennie Smith Memorial Ward." Our January committee has undertaken to make certain of the changes, as far as our committee friend will permit. We will have estimates submitted and start the contemplated improvements at once.

Respectfully,

(Signed) Mrs. Howard M. Towles.

N. B.—Total amount for month, $602.18.

The University of Maryland was founded in 1807, and about fifteen years later, or in 1821, the hospital was added to its other departments, in order to give the students a more thorough knowledge in the practice of medicine.

The hospital has no endowment whatever, and is supported by the appropriation from the State, the fees received from private patients and the assistance given by the Lady Board of Managers. It is safe to say there is as much real charity done in this hospital as any other institution in the State. There were over 30,000 cases treated in the dispensary during the past year, for which no special appropriation whatever is made. There are a great number of free beds, all of which are nearly always filled. It seems to be one of the rules that there is "always room for one more," and in order to accomplish this, cots are used to such an extent that at times it is almost impossible to find room to walk in some of the wards.

All money is expended in a most economical manner, as the financial reports will show. The medical superintendent is the only medical man who receives a salary. All the residents give their services absolutely free, as do all the visiting physicians and surgeons, as far as the hospital funds are concerned. The cost of the nurses' training school is very little, considering its size, and the only expense in the way of wages and salaries, of any importance, is that paid to the office force, the laundry employes, engineers, orderlies, ser-

[illegible] etc., all of whom receive minimum salaries and wages. The cost of food and hospital supplies, however, is large, due to the fact that so many people are cared for, but with all this, the average daily per capita cost is less than that of any other general hospital in the city. The last report shows it to be $1.33 per day; compare this with other institutions, some of which run as high as almost three times that amount, and it will readily be seen that the money we have at our command is most economically expended.

During the past summer a great many improvements were made, such as "an entire new heating system, refurnishing several wards, painting, also new floors, etc.," feeling that conditions would continue as they had been for a number of months previous, but just about this time the effects of the recent business depression were felt and money came in much slower, although the hospital continued to remain taxed to its full capacity. This has caused a deficiency, and as it is our desire to do all we can to keep the hospital in as good physical and financial condition as it has been for the past few years, we would especially appreciate assistance at this time.

Dr. Lee E. Bransford, B.M.C., class of 1910, is [illegible] 241 W. 8th street, Jacksonville, Fla.

Dr. J. M. Buch, class of 1913, writes us as follows:

"Santiago, Cuba, January 22, 1915.

"Dr. Luther Winslow,

"Baltimore, Md.:

"Dear Doctor—Enclosed please find money order for one dollar to continue my subscription to THE HOSPITAL BULLETIN. It is always interesting to me to know what is happening in the 'old school.' Moreover, THE BULLETIN always brings good articles.

"Would appreciate it very much if you would let me know if there is another publication in the University, as I suppose 'Old Maryland' is not published any longer.

"Hoping you are well and with best regards to your father and brother,

"I am, very truly yours,

"J. M. BUCH."

Dr. Roland S. Clinton, class of 1914, has returned from a vacation spent at his home in North Carolina.

Dr. James C. Perry, Surgeon, U. S. P. H. S., class of 1885, who has been on duty at Ancon, Panama, Canal Zone, has been transferred to Washington, D. C.

The following have received appointments as clinical assistants at the University Hospital for the ensuing year:

Resident Surgeons—E. Newcomer, M.D., reappointed; W. H. Toulson, M.D., reappointed; T. M. Davis, M.D., reappointed; R. B. Hill, L. A. Buie, V. Demarco.

Resident Physicians—(Vacancy); M. J. Egan, B. L. Wilson, E. H. Tonolla.

Resident Obstetricians—(Vacancy); P. L. Rush, J. A. Bennett.

Resident Pathologists—W. V. Ziegler, G. H. Dorsey.

Resident Gynecologists—A. S. Coleman, M.D., W. H. Jenkins.

The following gentlemen have been nominated to the Methodist Hospital Association for the selection of interns in the Maryland General Hospital: C. C. Ayers, M.D., W. B. Blanchard, M.D., J. E. Dull, M.D., H. A. Merkle, F. E. Shipley, R. Binion, W. A. Bridges, K. McCullough, S. D. Shannon, C. H. Moses and C. E. Sina. Eight appointments will be made.

In the annual amphitheater examination for internships at Bayview the following gentlemen were appointed from the senior class: Messrs. D. P. Etzler, G. P. Ross, J. J. Waff, B.S., E. W. Lane, B.S., J. A. B. Lowry, H. Goldman, M. B. Sharkey.

At the eighth annual meeting of the Southern Medical Association, held in Richmond, Va., recently, Dr. Rupert Blue, Surgeon-General, U. S. Public Health Service, class of 1892, delivered an interesting address, entitled, "Anti-Plague Measures—With Special Reference to the New Orleans Campaign."

Dr. Blue was born in South Carolina in 1868. He was graduated from the University of Maryland in 1892, and became an intern in the Marine Hospital Service during the same year. The following year he was commissioned Assistant Surgeon, and promoted to the grade of Past Assistant Surgeon in 1897 and Surgeon in 1909. He was commissioned Surgeon-General of the Public

Health and Marine Hospital Service by President William Howard Taft, January 13, 1912, which appointment was won by noteworthy and meritorious service, especially evidenced in the suppression and eradication of bubonic plague in San Francisco in 1907, which work brought him instantly into such prominence that his fitness for the position of Surgeon-General could not but be recognized. A few years ago Dr. Blue spent some time in Europe studying preventive medicine as practiced there, and in 1910 graduated from the London School of Tropical Medicine. In May of the same year he was detailed to represent the Public Health and Marine Hospital Service at the International Congress on Medicine and Hygiene at Buenos Aires, and while there took advantage of the opportunity to study possible routes by which plague and yellow fever might be brought into the United States from South America. His last detail before his appointment as Surgeon-General was at Honolulu to act in an advisory capacity to the Hawaiian Board of Health and other departments of the Territorial Government to inaugurate a program to reduce to a minimum the introduction and spread of yellow fever or plague in the Territory after the opening of the Panama Canal. In 1909 the honorary degree of doctor of science was conferred upon him by his alma mater.

Dr. Nathan Winslow, class of 1901, of 3304 Walbrook avenue, announces that he will limit his practice to general surgery.

Dr. Robert L. Blake, B. M. C., class of 1905, of 857 Columbia avenue, recently delivered a lecture at the Young Men's Christian Association on the prevention of tuberculosis.

Dr. Thomas H. Legg, class of 1907, of Union Bridge, Md., was a recent visitor to the Hospital.

Dr. Oakley S. Gribble, class of 1904, of Mill Creek, W. Va., is taking a post-graduate course at the University.

Dr. N. E. Berry Iglehart, class of 1889, entertained the Medical Dinner Club, Saturday, January 16, at his residence, 1008 Cathedral street. The table was arranged in a color scheme of yellow. There are eighteen members in the club. They usually meet about four times during the winter.

Dr. Benjamin R. Benson, Jr., class of 1907, of Cockeysville, Md., was also a recent visitor to the University.

The annual dinner of the General Alumni Association of the University of Maryland was held at the Hotel Rennert, Baltimore, Saturday evening, February 20, 1915, at 6.30 P. M. The election of officers, members of the executive committee and members of the alumni advisory council took place just before the dinner, for which a very attractive menu had been arranged. Several interesting speeches were given by members of the association from this and other States. Judge Walter I. Dawkins was the toastmaster, and, besides introducing the speakers, kept everyone in a happy mood with his witty remarks.

Dr. Thomas Fell, president of St. John's College, was one of the chief speakers. He praised the Maryland University graduates and referred with emphasis to the fact that the average alumnus of the old University takes equal rank in the affairs of life with the graduates of more pretentious institutions, and urged the alumni to be the living Maryland and to build upon the foundation which has been so nobly laid in the past.

Dr. Randolph Winslow, in the course of a speech, called attention to the fact that the Council on Education of the American Medical Association had already stated its desire to have only two medical schools in Baltimore, and intimated that if this were to come to fruition the two schools would logically be Johns Hopkins Medical School and the University of Maryland School of Medicine.

Among the other speakers were W. H. Lovell, president of the Pennsylvania Association; Rebt. C. White; William M. Maloy, provost of the Maryland State University; Addison E. Mulliken, William H. Maltbie, A. C. Coble, A. F. Laufman, Oregon Milton Dennis and Dr. J. C. C. Beale, secretary-treasurer of the Pennsylvania branch of the association.

The plans for organizing the State University formed the keynote of the addresses, and emphasis was laid upon the responsibility of the members of the faculties and alumni associations of the constituent institutions in urging the Legis-

future to appropriate sufficient funds for maintenance.

Officers were elected for the ensuing year as follows:

President—Eugene W. Hodson, Phar.D.
Vice-President—E. J. W. Revell, LL.B.
Treasurer—William K. Stichel, Phar.D.
Recording Secretary—Dr. Albert H. Carroll.
Corresponding Secretary—Edw. P. Crummer, LL.B.

Advisory Council: Medical—Dr. Charles E. Sadtler, Dr. Charles Getz and Dr. Harry Adler. Legal—James W. Bowers, Frank V. Rhodes and John Henry Skeen. Dental—Dr. H. H. Gorgas, Dr. Charles C. Harris and Dr. L. Wilson Davis. Pharmaceutical—John B. Thomas, John A. Hancock and E. F. Kelly. Academic—Judge Walter I. Dawkins, Dr. James A. Nydegger and Dr. J. W. Iglehart.

Dr. David B. Hoag, class of 1890, of 57 W. 50th street, New York, has been elected adjunct professor of nervous and mental diseases at the New York Polyclinic Medical School and Hospital. Dr. Hoag was the valedictorian of his class. For the past five years he has been on the teaching staff of the New York University and Bellevue Hospital Medical College, and for six years surgeon to the American Automobile Association.

The February meeting of the University of Maryland Medical Society was held in the hospital amphitheater Wednesday, February 17, 1915. Dr. Ernest Zueblin, professor of medicine, read an interesting paper on "Radio-Therapy in Chronic Arthritis," and Dr. William H. Smith, class of 1900, on "Acidosis in Heart and Kidney Conditions."

Since our last issue, two of our Baltimore alumni have moved. They are Drs. Albert H. Carroll and Robert P. Bay. Both have taken apartments in the Walbert.

BIRTHS

To Mr. and Mrs. Thomas Reese Cornelius of Govans, Md., February 7, 1915, a son. Mrs. Cornelius was before her marriage Miss Maude F. Smith, University Hospital Training School for Nurses, class of 1908.

To Mr. and Mrs. Douglas C. Blackwell of Reedville, Va., December 10, 1914, a son. Mrs. Blackwell was before her marriage Miss Lucy C. Barber, University Hospital Training School for Nurses, class of 1910.

Recently, to Mr. and Mrs. Stanley Blood of Brookline, Mass., a son. Mrs. Blood was before her marriage Miss Lela Munder, University Hospital Training School for Nurses, class of 1914.

To Dr. Harry D. McCarthy, class of 1905, and Mrs. McCarty, of 37 W. Preston street, February 18, 1915, a son—Horatio Ball.

MARRIAGES

Dora I. Brosene, R. N., University Hospital Training School for Nurses, class of 1905, formerly of Baltimore, Md., to Mr. Oliver of Washington, D. C., at Washington, recently.

Dr. Henry E. Jenkins, class of 1905, Assistant Surgeon, U. S. N., of Norfolk, Va., to Miss Gatewood of Washington, D. C., daughter of Captain and Mrs. James D. Gatewood, U. S. N., at Washington, in October, 1914. Dr. Jenkins is stationed in Washington.

DEATHS

Dr. Henry C. Shipley, class of 1865, formerly of Eldersburg, Carroll county, Md., but for the last 13 years a resident of Washington, D. C., died at the home of his daughter, 1935 Summit Place N. E., Washington, after a lingering illness, February 11, 1915. Dr. Shipley is survived by three children, Mrs. R. W. Pearson, Mrs. Allen Smith of Washington and Marriott Shipley of Sykesville, Md.

Dr. Kurt Seyforth, class of 1885, formerly professor of languages in the Baltimore City College, died at his home in Baltimore January 9, 1915, from diseases of the liver, aged 62 years.

Dr. Thomas F. Keen, class of 1881, formerly a member of the Medical Society of Virginia, president of the Hamilton (Va.) Bank, one of the most widely known practitioners of Northern Virginia, died at his home in Hamilton, January 24, 1915, aged 57 years.

UNIVERSITY OF MARYLAND
SCHOOL OF MEDICINE

THOMAS FELL, A.M., Ph.D., LL.D., D.C.L. - - Provost

FACULTY OF PHYSIC

SAMUEL C. CHEW, M. D., LL. D., Emeritus Professor of Medicine.
R. DORSEY COALE, M. D., Ph. D., Professor of Chemistry and Toxicology.
RANDOLPH WINSLOW, A. M., M. D., LL. D., Professor of Surgery.
L. E. NEALE, M. D., LL. D., Professor of Obstetrics.
CHAS. W. MITCHELL, A. M., M. D., Professor of Pediatrics and Clinical Medicine.
THOS. A. ASHBY, M. D., LL. D., Professor of Diseases of Women.
JOHN HOLMES SMITH, M. D., Professor of Anatomy.
JOHN C. HEMMETER, M. D., Ph. D., Sc. D., LL. D., Professor of Physiology and Clinical Medicine.
A. M. SHIPLEY, M. D., Professor of Materia Medica and Surgical Pathology.
DAVID STREETT, A. M., M. D., Professor of Practice of Medicine.
S. K. MERRICK, M.D., Professor of Diseases of the Nose and Throat.
R. B. WARFIELD, M. D., Professor of Practice of Surgery.
GORDON WILSON, M. D., Professor of Clinical Medicine.
ERNEST ZUEBLIN, M. D., Professor of Medicine.
JOSE L. HIRSH, B. A., M. D., Professor of Pathology and Bacteriology.
HIRAM WOODS, JR., M. A., M. D., Professor of Eye and Ear Diseases.
JOHN S. FULTON, A. B., M. D., Professor of State Medicine.
DANIEL BASE, B. A., Ph. D., Professor of Analytical Chemistry.
HARRY ADLER, B. A., M. D., Professor of Therapeutics and Clinical Medicine.
THOMAS C. GILCHRIST, M. R. C. S., M. D., Professor of Dermatology.
FRANK MARTIN, B. S., M. D., Professor of Operative and Clinical Surgery.
CHARLES G. HILL, A. M., M. D., Professor of Psychiatry.
A. C. POLE, M. D., Professor of Descriptive Anatomy.
J. D. BLAKE, M. D., Professor of Clinical Surgery.
J. FRANK CROUCH, M. D., Professor of Clinical Ophthalmology and Otology.
J. M. H. ROWLAND, M. D., Professor of Clinical Obstetrics.
CHARLES O'DONOVAN, A. M., M. D., LL. D., Professor of Clinical Pediatrics and Clinical Medicine.
G. MILTON LINTHICUM, A. M., M. D., Professor of Proctology.
W. P. PERRY, M. D., Professor of Clinical Gynecology.
TILGHMAN B. MARDEN, A. B., M. D., Professor of Histology and Embryology.
J. MASON HUNDLEY, M. D., Professor of Clinical Gynecology.
JOSEPH T. SMITH, M. D., Professor of Medical Jurisprudence and Hygiene.
ST. CLAIR SPRUILL, M. D., Professor of Clinical Surgery.
R. TUNSTALL TAYLOR, M. D., Professor of Orthopedic Surgery.
JOHN R. WINSLOW, B. A., M. D., Professor of Diseases of the Throat and Nose.
J. M. CRAIGHILL, M. D., Professor of Clinical Medicine.
JOS. E. GICHNER, M. D., Professor of Clinical Medicine and Physical Therapeutics.
CHAS. M. McELFRESH, M. D., Professor of Clinical Medicine.
IRVING J. SPEAR, M. D., Professor of Nervous Diseases.
JAMES A. NYDEGGER, M. A., M. D., Sc. D., Surgeon U. S. P. H. Service, Professor of Tropical Medicine.
GIDEON TIMBERLAKE, M. D., Professor of Genito-Urinary Diseases.
JOHN G. JAY, M. D., Clinical Professor of Surgery.
NATHAN WINSLOW, A. M., M. D., Clinical Professor of Surgery.
PAGE EDMUNDS, M. D., Clinical Professor of Genito-Urinary Diseases.
RICHARD H. JOHNSTON, A. B., M. D., Clinical Professor of Diseases of the Nose and Throat.
JOSEPH W. HOLLAND, M. D., Associate Professor of Anatomy.
T. L. PATTERSON, M. A., Associate Professor of Biology and Physiology.
WILLIAM TARUN, M. D., Associate Professor of Diseases of the Eye and Ear.
G. C. LOCKARD, M. D., Associate Professor of Clinical Medicine and Pediatrics.
E. L. WHITNEY, M. D., Associate Professor of Physiological Chemistry, Pharmacology and Clinical Pathology.
E. B. FREEMAN, S. B., M. D., Associate Professor of Clinical Medicine.
WILLIAM CASPARI, JR., Ph. G., M. D., Associate Professor of Materia Medicine.
H. R. SPENCER, M. D., Associate Professor of Pathology and Bacteriology.
E. R. STROBEL, A. B., M. D., Associate Professor of Dermatology.
W. B. WOLF, M. D., Associate Professor of Genito-Urinary Diseases.
THOMAS W. KEOWN, A. B., M. D., Associate Professor of Clinical Medicine.
J. CLEMENT CLARK, M. D., Associate Professor of Psychiatry.
H. W. BRENT, M. D., Associate Professor of Gynecology.